		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040543

Facility Name: Tabor Hills Health Care Facility

Address: 1347 Crystal Court (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: (630) 778-6677 **Fax #** (630) 778-6680

IDPA ID Number: 363867476001

Date of Initial License for Current Owners: 04/28/95

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Mr. Charles Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2001 to 9/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	147	Intermediate (ICF)	147	53,655	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	81	476	4,269	4,826	8
9	SNF/PED					9
10	ICF	31,149	35,834		66,983	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,230	36,310	4,269	71,809	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.24%

D. How many bed-hold days during this year were paid by Public Aid? 119 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 04/28/95

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 4/28/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 4,269

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/2002 Fiscal Year: 9/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	368,551	27,018	8,528	404,097		404,097		404,097			1
2	Food Purchase		309,199		309,199		309,199		309,199			2
3	Housekeeping	254,423	67,355	27,561	349,339		349,339		349,339			3
4	Laundry	105,094	65,709	183	170,986		170,986		170,986			4
5	Heat and Other Utilities			222,186	222,186		222,186		222,186			5
6	Maintenance	139,830	37,462	192,656	369,948		369,948		369,948			6
7	Other (specify):*											7
8	**TOTAL General Services**	867,898	506,743	451,114	1,825,755		1,825,755		1,825,755			8
	B. Health Care and Programs											
9	Medical Director			23,210	23,210		23,210		23,210			9
10	Nursing and Medical Records	3,680,183	280,074	962,749	4,923,006		4,923,006	507	4,923,513			10
10a	Therapy	272,395	64,185	34,767	371,347		371,347		371,347			10a
11	Activities	113,605	2,973	5,765	122,343		122,343		122,343			11
12	Social Services	97,976	968	5,030	103,974		103,974		103,974			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,164,159	348,200	1,031,521	5,543,880		5,543,880	507	5,544,387			16
	C. General Administration											
17	Administrative	147,672			147,672		147,672		147,672			17
18	Directors Fees											18
19	Professional Services			243,565	243,565		243,565	(14,272)	229,293			19
20	Dues, Fees, Subscriptions & Promotions			61,477	61,477		61,477		61,477			20
21	Clerical & General Office Expenses	358,748	44,601	63,686	467,035		467,035	(9,752)	457,283			21
22	Employee Benefits & Payroll Taxes			1,595,426	1,595,426		1,595,426		1,595,426			22
23	Inservice Training & Education			435	435		435		435			23
24	Travel and Seminar			15,582	15,582		15,582	(507)	15,075			24
25	Other Admin. Staff Transportation			7,207	7,207		7,207		7,207			25
26	Insurance-Prop.Liab.Malpractice			280,574	280,574		280,574		280,574			26
27	Other (specify):*											27
28	**TOTAL General Administration**	506,420	44,601	2,267,952	2,818,973		2,818,973	(24,531)	2,794,442			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,538,477	899,544	3,750,587	10,188,608		10,188,608	(24,024)	10,164,584			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tabor Hills Health Care Facility #0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			466,034	466,034		466,034	5,080	471,114			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			469,789	469,789		469,789	(13)	469,776			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			935,823	935,823		935,823	5,067	940,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		110,530		110,530		110,530		110,530			39
40	Barber and Beauty Shops			30,155	30,155		30,155		30,155			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):* **Nonallowable Costs**			110,927	110,927		110,927	(110,927)				43
44	**TOTAL Special Cost Centers**		110,530	256,605	367,135		367,135	(110,927)	256,208			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,538,477	1,010,074	4,943,015	11,491,566		11,491,566	(129,884)	11,361,682			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,080	30		9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,237)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,090)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached schedule 5A	(119,624)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (129,884)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (129,884)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility
IDPH Facility # 0040543
9.30.02

Schedule 5A

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Disallow resident insurance	(2,270.00)	43
Disallow resident physicians	(3,817.00)	43
Disallow miscellaneous expense	(11,454.00)	43
Disallow X-Ray expense	(63,715.00)	43
Disallow Lab expense	(14,173.00)	43
Disallow Clothing expense	(171.00)	43
Miscellaneous income offset	(9,752.00)	21
Disallow out of period legal fees	(14,272.00)	19
Total	(119,624.00)	

See Accountants' Compilation Report

Tabor Hills Health Care Facility

ID# 0040543

Report Period Beginning: 10/1/2001

Ending: 9/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tabor Hills Health Care Facility **#** 0040543 **Report Period Beginning:** 10/1/2001 **Ending:** 9/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/1/2001 **Ending:** 9/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,080	0	0	0	0	0	0	0	0	0	0	5,080	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13)	0	0	0	0	0	0	0	0	0	0	(13)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,067	0	0	0	0	0	0	0	0	0	0	5,067	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,327)	0	0	0	0	0	0	0	0	0	0	(15,327)	43
44	**TOTAL Special Cost Centers**	(15,327)	0	0	0	0	0	0	0	0	0	0	(15,327)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,260)	0	0	0	0	0	0	0	0	0	0	(10,260)	45

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bohemian Home for the Aged	100			Bohemian Home for the Aged	Naperville	Townhomes
See attached schedule 6A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V				N/A				5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3		N/A									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5					N/A					5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Northwest Bank of Wisconsin		X	Mortgage	Principal and	3/31/1998	$ 8,095,000	$ 7,638,300	11/2024	Varies	$ 449,564	1
2					Interest due							2
3					Semi-annually							3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,095,000	$ 7,638,300			$ 449,564	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(13)	12
13								Amortization of Loan Fees			20,225	13
14	TOTAL Non-Facility Related						$	$			$ 20,212	14
15	TOTALS (line 9+line14)						$ 8,095,000	$ 7,638,300			$ 469,776	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ n/a Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tabor Hills Health Care Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0040543

CONTACT PERSON REGARDING THIS REPORT Ms. Gloria Pindiak

TELEPHONE (630) 778-6677 FAX #: (630) 778-6680

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,980 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Bohemian Home for the Aged d/b/a Tabor Hills Adult Community provides housing to seniors through an adult living community.
There are 104 townhomes and a total of 1,267,596 square feet of land.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	264,519	1995	$ 574,693	1
2					2
3	TOTALS	264,519		$ 574,693	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 10,039,753	$ 249,932	40	$ 250,994	$ 1,062	$ 1,881,918	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land improvements			1995	36,958	2,751	15	2,464	(287)	18,479	9
10	Improvements			1995	1,421		40	36	36	399	10
11	Sign			1997	500	13	40	13		71	11
12	Electric			1996	656	16	40	16		88	12
13	Humidistats			1996	1,378	34	40	34		187	13
14	Door alarm			1996	854	22	40	22		121	14
15	Plumbing			1996	1,050	26	40	26		143	15
16	Install lights, water heater			1997	2,345	58	40	58		319	16
17	Pipe			1997	618	16	40	16		88	17
18	Electric			1997	3,121	78	40	78		429	18
19	Signs & outlets			1997	2,504	62	40	62		341	19
20	Wall hugging overbed lights			1997	27,302	671	40	671		3,708	20
21	Air compressor			1997	2,078	52	40	52		286	21
22	Roof repair			1997	3,154	78	40	78		429	22
23	Deco-gard products			1997	738	18	40	18		100	23
24	Shelving units			1998	2,317	58	40	58		261	24
25	Chimney cap			1998	945	95	40	24	(71)	108	25
26	Access door			1998	2,061	52	40	52		234	26
27	Bumper guards			1998	3,687	92	40	92		414	27
28	Land improvement - survey			1998	800		10	80	80	360	28
29	Carpeting			1999	67,303	6,730	10	6,730		22,995	29
30	Miniblinds			1999	3,501	350	10	350		1,079	30
31	Vertical blinds			1999	1,974	197	10	197		756	31
32	Swingmaster door			1999	2,357	236	10	236		904	32
33	Security lock			1999	2,779	278	10	278		996	33
34	WanderGuard code alert system			1999	16,182		10	1,618	1,618	5,663	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2000	$ 225	$ 22	10	$ 22	$	$ 47	37
38	Railing & Bumper	2000	3,275	81	40	81		209	38
39	Carpeting	2000	41,999	4,200	10	4,200		8,050	39
40	Tile	2001	6,493	135	40	135		135	40
41	Courtyard improvements	2001	15,673	33	40	33		33	41
42	Architect Fees - Dining room	2002	58,322		10				42
43	Carpet	2002	3,341		10				43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,357,664	$ 266,386		$ 268,824	$ 2,438	$ 1,949,350	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,779,517	$ 177,931	$ 180,942	$ 3,011	5-10	$ 1,267,965	71
72	Current Year Purchases	120,752	5,822	5,822		5-10	5,822	72
73	Fully Depreciated Assets	18,703				5	18,703	73
74								74
75	TOTALS	$ 1,918,972	$ 183,753	$ 186,764	$ 3,011		$ 1,292,490	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Schedule 13A			$ 130,845	$ 19,401	$ 15,526	$ (3,875)	5	$ 92,989	76
77										77
78										78
79										79
80	TOTALS			$ 130,845	$ 19,401	$ 15,526	$ (3,875)		$ 92,989	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,982,174	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 469,540	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 471,114	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,574	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,334,829	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-care related Bus	$ 38,750	$	$ 38,750	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 38,750	$	$ 38,750	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
9.30.02

Schedule 13A

Schedule XI - D Vehicle Depreciation

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Life in Years	Accumulated Depreciation
Medical Transportation	1988 Ford Van	1988	23,216.00			-	5	23,216.00
Facility Use	2001 Chrysler Van	2001	31,409.00	4,711.00	4,711.00	-	5	9,422.00
Non-care related	Bus			3,875.00	-	(3,875.00)	5	-
Administrative Use	2000 Chrysler Van	2000	31,930.00	6,386.00	6,386.00	-	5	16,061.00
Facility Use	1997 Ford Eldorado Bus	1997	44,290.00	4,429.00	4,429.00	-	5	44,290.00
			130,845.00	19,401.00	15,526.00	(3,875.00)		92,989.00

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C1 & C3	1203 hrs	$ 35,896	68	$ 2,742	$	1,271	$ 38,638	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,682	26,917		1,682	26,917	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C1, C2	3357 hrs	134,247	150	5,108	20,209	3,507	159,564	4
5	Physician Care	& C3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				110,530		110,530	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L10a, C2					43,976		43,976	13
14	TOTAL			$ 170,143	1,900	$ 34,767	$ 174,715	6,460	$ 379,625	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 244,963	$ 244,963	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	798,636	798,636	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	297,254	297,254	6
7	Other Prepaid Expenses	33,854	33,854	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,374,707	$ 1,374,707	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,693	574,693	13
14	Buildings, at Historical Cost	9,997,265	10,039,753	14
15	Leasehold Improvements, at Historical Cost	357,155	317,911	15
16	Equipment, at Historical Cost	2,098,827	2,049,817	16
17	Accumulated Depreciation (book methods)	(3,375,585)	(3,334,829)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spc **See Schedule 17A**	290,449	290,449	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,942,804	$ 9,937,794	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,317,511	$ 11,312,501	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 357,851	$ 357,851	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	170,100	170,100	29
30	Accrued Salaries Payable	306,295	306,295	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	174,473	174,473	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	232,911	232,911	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,241,630	$ 1,241,630	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,468,200	7,468,200	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,468,200	$ 7,468,200	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,709,830	$ 8,709,830	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,607,681	$ 2,602,671	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,317,511	$ 11,312,501	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
9.30.02

Schedule 17A

XV. Balance Sheet

B. Long Term Assets - Line 22

	Operating	After Consolidation
Finance Fees	$ 251,843.00	$ 251,843.00
Construction in Progress	$ 38,606.00	$ 38,606.00
Total	**$ 290,449.00**	**$ 290,449.00**

C. Current Liabilities - Line 36

	Operating	After Consolidation
Resident Credit Balances	$(201,463.00)	$ (201,463.00)
Other Liab. - Phone Equip.	$ (30,667.00)	$ (30,667.00)
Accrued Wage Assignment	$ (781.00)	$ (781.00)
Total	**$(232,911.00)**	**$ (232,911.00)**

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,546,615	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,546,615	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(300,269)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (300,269)	17
	B. Transfers (Itemize):		
18			18
19	**Interorganization transfers**	(638,665)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (638,665)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,607,681	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,428,281	1
2	Discounts and Allowances for all Levels	(673,514)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,754,767	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	511,283	6
7	Oxygen	85,757	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 597,040	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	29,919	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	7,464	15
16	Rental of Facility Space		16
17	Sale of Drugs	131,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,146	19
20	Radiology and X-Ray	90,779	20
21	Other Medical Services	382,908	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 654,478	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Revenue	184,999	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 184,999	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,191,297	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,825,755	31
32	Health Care	5,543,880	32
33	General Administration	2,818,973	33
	B. Capital Expense		
34	Ownership	935,823	34
	C. Ancillary Expense		
35	Special Cost Centers	251,612	35
36	Provider Participation Fee	115,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,491,566	40
41	**Income before Income Taxes (line 30 minus line 40)****	(300,269)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (300,269)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**
This facility is a not-for-profit organization. It is not subject to income taxes.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,923	2,091	$ 59,536	$ 28.47	1
2	Assistant Director of Nursing	1,818	2,091	51,684	24.72	2
3	Registered Nurses	49,530	53,080	1,243,647	23.43	3
4	Licensed Practical Nurses	16,925	18,260	359,608	19.69	4
5	Nurse Aides & Orderlies	119,660	127,089	1,585,238	12.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,050	4,560	170,143	37.31	7
8	Rehab/Therapy Aides	10,796	11,893	127,234	10.70	8
9	Activity Director	1,719	2,091	27,530	13.17	9
10	Activity Assistants	8,304	9,800	86,075	8.78	10
11	Social Service Workers	7,815	8,803	97,976	11.13	11
12	Dietician					12
13	Food Service Supervisor	1,874	2,159	41,783	19.35	13
14	Head Cook	3,800	4,336	56,584	13.05	14
15	Cook Helpers/Assistants	27,934	30,367	255,178	8.40	15
16	Dishwashers	2,018	2,166	15,006	6.93	16
17	Maintenance Workers	7,331	7,813	139,830	17.90	17
18	Housekeepers	31,538	34,487	254,423	7.38	18
19	Laundry	11,646	12,519	105,094	8.39	19
20	Administrator	1,862	2,091	91,027	43.53	20
21	Assistant Administrator	1,859	2,091	56,645	27.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,122	23,921	358,748	15.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,678	5,010	66,988	13.37	31
32	Other Health Ca See Schedule 20A	12,399	13,461	288,500	21.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	351,601	380,179	$ 5,538,477 *	$ 14.57	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,528	L1, C3	35
36	Medical Director	Monthly	23,210	L9, C3	36
37	Medical Records Consultant	138	3,181	L10, C3	37
38	Nurse Consultant	Monthly	16,827	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	3,466	L11,C3	44
45	Social Service Consultant	85	5,030	L12, C3	45
46	Other(specify)				46
47	Alzheimers Consultant	42	1,814	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	325	$ 62,056		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10,957	$ 448,441	L10, C3	50
51	Licensed Practical Nurses	2,695	82,468	L10, C3	51
52	Nurse Aides	20,570	410,018	L10, C3	52
53	TOTAL (lines 50 - 52)	34,222	$ 940,927		53

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
9.30.02

Schedule 20A

Page 20 - Schedule XVIII. A. Staffing and Salary Costs
Line 32 - Other

Description	Hours Worked	Hours Paid	Wages	Average Wages
Wound Care Coordinator	1,980.00	2,304.00	52,114.00	**22.62**
Ward Clerk	3,430.00	3,510.00	63,182.00	**18.00**
MDS Care Plan Coordinator	3,321.00	3,703.00	70,952.00	**19.16**
Rehabilitation Coordinator	1,382.00	1,578.00	31,258.00	**19.81**
Physical Rehabilitation	2,286.00	2,366.00	70,994.00	**30.01**
Total	12,399.00	13,461.00	288,500.00	

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gloria Pindiak	Administrator	0	$ 91,027
Clara Leonard	Asst. Administrator	0	56,645
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,672

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 243,565

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 226,395
Unemployment Compensation Insurance	4,260
FICA Taxes	408,782
Employee Health Insurance	187,616
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	4,162
Employee Appreciation	15,041
Employee Physicals	5,706
Employee Pension	681,126
Life/Disability Insurance	26,258
401(k) Expense	31,559
Other Employee Benefits	4,521
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,595,426

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	43,345
Health Care Worker Background Check	
(Indicate # of checks performed 95)	1,138
Life Services Network of Illinois	9,582
License, Permits & Inspections	1,072
Subscriptions	2,455
Membership Dues	3,570
ACHCA	255
Miscellaneous	60
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,477

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	15,075
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,075

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
9.30.02

Schedule 21A

XIX. C. Support Schedules - Line 19

Vendor/Payee	Type	Total
Duane Morris	Legal	65,958.00
Burke, Warren, MacKay & Serritella, P.C.	Legal	66,003.00
Erickson, Papanek, Hanson & Peterson	Legal	4,539.00
Esquire Deposition Services	Legal	577.00
John D. Rea	Legal	95.00
McCorkle Court Reporters	Legal	747.00
Burke & Rabin	Consultants	2,182.00
Altschuler, Melvoin & Glasser, LLP	Audit & Accounting	62,551.00
American Express Tax & Business Services	Tax & Accounting	12,789.00
Intech Consulatnts, Inc.	Architect	1,277.00
HDSI	Computer Services	7,753.00
Vopenka & Associated	Computer Services	3,030.00
Ivans	Computer Services	408.00
Clara Leonard	Computer Services	147.00
Lucas Leonard	Computer Services	100.00
Netsource Communications, Inc.	Computer Services	133.00
America Online Services	Computer Services	243.00
SDT	Computer Services	112.00
Med E America	Computer Services	649.00
Agrees to Schedule V, Line 19, Column 8		**229,293.00**
Non-allowable Legal Fees		14,272.00
Agrees to Schedule V, Line 19, Column 3		243,565.00

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4							N/A						
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois - $9,582**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **84,355** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,523**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress, will submit upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Tabor Hills Health Care** **04:29 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL
Adjustment Detail	-129,884	equal to	-129,884	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29
Interest Expense	469,776	equal to	469,776	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12
Ownership Costs-Depreciation	471,114	equal to	471,114	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23
Special Serv.- Staff Wages	170,143	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22
Therapy Services	225,119	equal to	371,347	-146,228	FAILED	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A;B	1-4;40-43	8;2	Pg3 H20
Special Serv.- Supplies	174,715	equal to	174,715	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3
Income Stat. General Serv.	1,825,755	equal to	1,825,755	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16
Income Stat. Health Care	5,543,880	equal to	5,543,880	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26
Income Stat. Admininstation	2,818,973	equal to	2,818,973	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39
Income Stat. Ownership	935,823	equal to	935,823	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18
Income Stat. Special Cost Ctr	251,612	equal to	251,612	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H
Income Stat. Prov. Partic.	115,523	equal to	115,523	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25
Staff- Nursing	3,655,201	equal to	3,680,183	-24,982	FAILED	Pg20 K11..K15+K35+K36+K38..K43	A.	1-5,24,25,27-30	3	Pg3 E19
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23
Staff-Licensed Therapist	170,143	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22
Staff- Activities	113,605	equal to	113,605	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21
Staff- Social Serv. Workers	97,976	equal to	97,976	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22
Staff- Dietary	368,551	equal to	368,551	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9
Staff- Maintenance	139,830	equal to	139,830	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14
Staff- Housekeeping	254,423	equal to	254,423	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11
Staff- Laundry	105,094	equal to	105,094	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12
Staff- Administrative	147,672	equal to	147,672	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28
Staff- Clerical	358,748	equal to	358,748	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18
Total Salaries And Wages	5,538,477	equal to	5,538,477	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29
Dietary Consultant	8,528	< or = to	8,528	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9
Medical Director	23,210	< or = to	23,210	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18
Consultants & contractors	960,935	< or = to	962,749	-1,814	O.K.	Pg20 X14..X16+X37..X39	B. & C.	37to39 and 50to5	2	Pg3 G19
Activity Consultant	3,466	< or = to	5,765	-2,299	O.K.	Pg20 X21	B.	44	2	Pg3 G21
Social Service Consultant	5,030	< or = to	5,030	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22
Supp. Sched.- Admin. Salar.	147,672	equal to	147,672	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28
Supp. Sched.- Prof. Serv.	243,565	equal to	243,565	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30
Supp. Sched.- Benefit/Taxes	1,595,426	equal to	1,595,426	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33
Supp. Sched.- Sched of dues..	61,477	equal to	61,477	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31
Supp. Sched.- Sched. of trav	15,075	equal to	15,075	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35
Gen. Info - Particip. Fees	115,523	equal to	115,523	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23
Days of medicare provided	4,269	equal to	4,269	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4(
Total loan balance	7,638,300	equal to	7,638,300	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17
Land	574,693	equal to	574,693	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25
Building cost	10,357,664	equal to	10,357,664	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27
Equipment and vehicle cost	2,049,817	equal to	2,049,817	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28
Accumulated depr.	3,334,829	equal to	3,334,829	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29
End of year equity	2,607,681	equal to	2,607,681	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39
Net income (loss)	-300,269	equal to	-300,269	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30
Balance Sheet	11,317,511	equal to	11,317,511	0	O.K.	Pg17:H41		25	1	Pg17 S41

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	368,551	27,018	8,528	404,097	0	404,097	0	404,097
2. Food P	0	309,199	0	309,199	0	309,199	0	309,199
3. Housek	254,423	67,355	27,561	349,339	0	349,339	0	349,339
4. Laundry	105,094	65,709	183	170,986	0	170,986	0	170,986
5. Heat ar	0	0	222,186	222,186	0	222,186	0	222,186
6. Mainter	139,830	37,462	192,656	369,948	0	369,948	0	369,948
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	867,898	506,743	451,114	1,825,755	0	1,825,755	0	1,825,755
9. Medical	0	0	23,210	23,210	0	23,210	0	23,210
10. Nursin	3,680,183	280,074	962,749	4,923,006	0	4,923,006	507	4,923,513
10a. Ther	272,395	64,185	34,767	371,347	0	371,347	0	371,347
11. Activit	113,605	2,973	5,765	122,343	0	122,343	0	122,343
12. Social	97,976	968	5,030	103,974	0	103,974	0	103,974
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	4,164,159	348,200	1,031,521	5,543,880	0	5,543,880	507	5,544,387
17. Admin	147,672	0	0	147,672	0	147,672	0	147,672
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	243,565	243,565	0	243,565	-14,272	229,293
20. Fees,	0	0	61,477	61,477	0	61,477	0	61,477
21. Clerica	358,748	44,601	63,686	467,035	0	467,035	-9,752	457,283
22. Emplo	0	0	1,595,426	1,595,426	0	1,595,426	0	1,595,426
23. Inserv	0	0	435	435	0	435	0	435
24. Travel	0	0	15,582	15,582	0	15,582	-507	15,075
25. Other	0	0	7,207	7,207	0	7,207	0	7,207
26. Insura	0	0	280,574	280,574	0	280,574	0	280,574
27. Other	0	0	0	0	0	0	0	0
28. Total (	506,420	44,601	2,267,952	2,818,973	0	2,818,973	-24,531	2,794,442
29. Total (	5,538,477	899,544	3,750,587	########	0	########	-24,024	########
30. Depre	0	0	466,034	466,034	0	466,034	5,080	471,114
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	469,789	469,789	0	469,789	-13	469,776
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	0	0	0	0	0	0
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	935,823	935,823	0	935,823	5,067	940,890
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	110,530	0	110,530	0	110,530	0	110,530
40. Barber	0	0	30,155	30,155	0	30,155	0	30,155
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	115,523	115,523	0	115,523	0	115,523
43. Other	0	0	110,927	110,927	0	110,927	-110,927	0
44. Total S	0	110,530	256,605	367,135	0	367,135	-110,927	256,208
45. Grand	5,538,477	1,010,074	4,943,015	########	0	########	-129,884	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	244,963	244,963
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	798,636	798,636
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	297,254	297,254
7. Other Prepaid Expenses	33,854	33,854
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,374,707	1,374,707
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	574,693	574,693
14. Buildings, at Historical Cost	9,997,265	10,039,753
15. Leasehold Improvements, Historical Cost	357,155	317,911
16. Equipment, at Historical Cost	2,098,827	2,049,817
17. Accumulated Depreciation (book methods)	-3,375,585	-3,334,829
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	290,449	290,449
23. other (specify):	0	0
24. Total Long-Term Assets	9,942,804	9,937,794
25. Total Assets	11,317,511	11,312,501
CURRENT LIABILITIES		
26. Accounts Payable	357,851	357,851
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	170,100	170,100
30. Accrued Salaries Payable	306,295	306,295
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	174,473	174,473
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	232,911	232,911
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,241,630	1,241,630
LONG TERM LIABILITES		
39.Long-Term Notes Payable	7,468,200	7,468,200
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	7,468,200	7,468,200
46.Total Liabilities	8,709,830	8,709,830
47.Total Equity	2,607,681	2,602,671
48.Total Liabilities and Equity	11,317,511	11,312,501

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,428,281
2. Discounts and Allowances for all Levels	-673,514
Subtotal - Inpatient Care	9,754,767
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	511,283
7. Oxygen	85,757
Subtotal - Anciliary Revenue	597,040
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	29,919
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	7,464
16. Rental of Facility Space	0
17. Sale of Drugs	131,262
18. Sale of Supplies to Non-Patients	0
19. Laboratory	12,146
20. Radiologyand X-Ray	90,779
21. Other Medical Services	382,908
22. Laundry	0
Subtotal - Other Operating Revenue	654,478
24. Contributions	0
25. Interest and Other Investments Income	13
Subtotal - Non-Operating Revenue	13
27. Other Revenue (specify):	184,999
28. Other Revenue (specify):	0
Subtotal - Other Revenue	184,999
30. Total Revenue	11,191,297
31. General Services	1,825,755
32. Health Care	5,543,880
33. General Administration	2,818,973
34. Ownership	935,823
35. Special Cost Centers	251,612
35. Provider Participation Fee	115,523
37. Other	0
40. Total Expenses	11,491,566
41. Income Before Income Taxes	-300,269
42. Income Taxes	0
43. Net Income or Loss for the Year	-300,269

Page

Line 16 for mortgage insurance.